GROUPING	DATA NBR	STATE FIELDS/DEFINED ELEMENTS	MTC 00 REQS.	MTC 01 REQS.	MTC 02 REQS.	MTC 04 REQS.	MTC AU REQS.	MTC CO REQS.
TRANSACTION	1	TRANSACTION SET ID	M	M	M	M	M	M
	2	MAINTENANCE TYPE CODE	M	M	M	M	M	M
	3	MAINTENANCE TYPE CODE DATE	M	M	M	M	M	M
JURISDICTION	4	JURISDICTION	M	M	M	M	M	M
	5	AGENCY CLAIM NUMBER	C	M	M	C	C	M
CLAIM ADMINISTRATOR	6	INSURER FEIN	M	C	C	M	M	C
	7	INSURER NAME	M	C	C	M	M	C
	8	THIRD PARTY ADMINISTRATOR FEIN	C	C	C	C	C	C
	9	THIRD PARTY ADMINISTRATOR NAME	C	C	C	C	C	C
	10	CLAIM ADMINISTRATOR ADDRESS LINE 1	C	C	C	C	C	C
	11	CLAIM ADMINISTRATOR ADDRESS LINE 2	C	C	C	C	C	C
	12	CLAIM ADMINISTRATOR CITY	C	C	C	C	C	C
	13	CLAIM ADMINISTRATOR STATE	C	C	C	C	C	C
	14	CLAIM ADMINISTRATOR POSTAL CODE	C	C	C	C	C	C
	15	CLAIM ADMINISTRATOR CLAIM NUMBER	C	C	C	C	C	C
INSURED	16	EMPLOYER FEIN	M	C	C	M	M	C
	17	INSURED NAME	C	C	C	C	C	C
	18	EMPLOYER NAME	M	C	C	M	M	C
	19	EMPLOYER ADDRESS LINE 1	M	C	C	M	M	C
	20	EMPLOYER ADDRESS LINE 2	C	C	C	C	C	C
	21	EMPLOYER CITY	M	C	C	M	M	C
	22	EMPLOYER STATE	M	C	C	M	M	C
	23	EMPLOYER POSTAL CODE	M	C	C	M	M	C
	24	SELF INSURED INDICATOR	M	C	C	M	M	C
	25	SIC CODE	M	C	C	M	M	C
	26	INSURED REPORT NUMBER						
	27	INSURED LOCATION NUMBER						
POLICY	28	POLICY NUMBER						
	29	POLICY EFFECTIVE						
	30	POLICY EXPIRATION						
ACCIDENT	31	DATE OF INJURY	M	M	M*	M	M	M*
	32	TIME OF INJURY						
	33	POSTAL CODE OF INJURY SITE	M	C	C	M	M	C
	34	EMPLOYER'S PREMISES INDICATOR						
	35	NATURE OF INJURY CODE	M	M	M*	M	M	M*
	36	PART OF BODY INJURED CODE	M	M	M	M	M	M
	37	CAUSE OF INJURY CODE	M	M	M	M	M	M
	38	ACCIDENT DESCRIPTION/CAUSE	M	C	C	M	M	C
	39	INITIAL TREATMENT						
	40	DATE REPORTED TO EMPLOYER	M	M	M	M	M	M
	41	DATE REPORTED TO CLAIMS ADMINISTRATOR	M	M	M	M	M	M
CLAIMANT	42	SOCIAL SECURITY NUMBER	M	M	M*	M	M	M*
	43	EMPLOYEE LAST NAME	M	C	C	M	M	C
	44	EMPLOYEE FIRST NAME	M	C	C	M	M	C
	45	EMPLOYEE MIDDLE INITIAL	O	C	C	O	O	C
	46	EMPLOYEE ADDRESS LINE 1	M	C	C	M	M	C
	47	EMPLOYEE ADDRESS LINE 2	C	C	C	C	C	C
	48	EMPLOYEE CITY	M	C	C	M	M	C
	49	EMPLOYEE STATE	M	C	C	M	M	C
	50	EMPLOYEE POSTAL CODE	M	C	C	M	M	C
	51	EMPLOYEE PHONE	C	C	C	C	C	C
	52	EMPLOYEE DATE OF BIRTH	M	C	C	M	M	C
	53	GENDER CODE	M	C	C	M	M	C
	54	MARITAL STATUS CODE	O	C	C	O	O	C
	55	NUMBER OF DEPENDENTS	O	C	C	O	O	C
	56	DATE DISABILITY BEGAN	C	C	C	C	C	C
	57	EMPLOYEE DATE OF DEATH	C	C	C	C	C	C
EMPLOYMENT	58	EMPLOYMENT STATUS CODE						
	59	CLASS CODE						
	60	OCCUPATION DESCRIPTION	M	C	C	M	M	C
	61	DATE OF HIRE						
	62	WAGE	O	C	C	O	O	C
	63	WAGE PERIOD	C	C	C	C	C	C
	64	NUMBER OF DAYS WORKED	O	C	C	O	O	C
	65	DATE LAST DAY WORKED	M	C	C	M	M	C
	66	FULL WAGES PAID FOR DATE OF INJURY INDICATOR						
	67	SALARY CONTINUED INDICATOR	O	C	C	O	O	C
	68	DATE OF RETURN TO WORK	C	C	C	C	C	C

Blank Field = Not required by Jurisdiction   M* = Requires DWC Manual Change Request Form